# EXHIBIT 11

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS
NO. 01CV12257-PBS

In re: PHARMACEUTICAL )
INDUSTRY AVERAGE WHOLESALE )
PRICE LITIGATION )
)
THIS DOCUMENT RELATES TO: )
ALL ACTIONS )

DEPOSITION of STEVEN J. FOX, called as a witness by and on behalf of the Johnson & Johnson, pursuant to the applicable provisions of the Federal Rules of Civil Procedure, before P. Jodi Ohnemus, Notary Public, Certified Shorthand Reporter, Certified Realtime Reporter, and Registered Merit Reporter, within and for the Commonwealth of Massachusetts, at the offices of Robins, Kaplan, Miller & Ciresi, L.L.P., 800 Huntington Avenue, Boston, Massachusetts, on Wednesday, 8 March, 2006, commencing at 9:35 a.m.

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Q. Okay. How long did you remain in the claims processing role?
A. Six months.
Q. Okay. What was the next position that you moved to?
A. I would have brought a copy of my resume. I think the next position I had, I then left to go into what was then called "professional relations" as a coordinator. So, essentially, that was where I began my career working with physicians.
Q. And that was in the fall of '91?
A. Well, six months after that. So, probably -- I think I actually landed in that role -- it was probably by then 1992. So, whatever that -- not exactly sure of the time frames, but --
Q. Okay. Somewhere in the '91, '92 period?
A. Yeah. Yeah.
Q. Now, how long did you remain in the professional relations coordinator role?
A. I was probably a coordinator for a

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couple of years, just responsible for taking phone calls and assisting what we called provider representatives. So, individuals from our company that would go out and meet with physicians. Again, I was kind of an internally-based person. And then I stayed in that role for probably a couple of years, and then I later took a job as the external provider relations representative.
Q. Now, when you were in the coordinator role, were you taking calls only from the field reps or also from physicians directly?
A. No, I took calls from physicians directly. I was the person they called if they had an issue or things like that.
Q. Now, while you were in that role, BCBS of Massachusetts acquired Bay State Health Care, is that correct?
A. That's correct.
Q. When was that acquisition?
A. I think it was October of 1992.
Q. Now, Bay State Health Care also had a staff model HMO in the early '90s, is that

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correct?
MR. COCO: Objection.
A. No, I don't think -- I don't think we did.
Q. Do you understand what I mean when I use the term "staff model HMO"?
A. I do.
Q. What is your understanding of that term?
A. A group of employed physicians that were owned and operated by the health plan, but I don't -- our Bay State did not -- to my knowledge -- didn't own or employ physicians and did not have a clinic-based practice.
Q. Are you aware that other witnesses have testified that Bay State did, indeed, have a staff model HMO in the early '90s?
MR. COCO: Objection.
A. I'm not aware that they have.
Q. Well --
A. In my role, again, if there was, I had no involvement with it. So, my understanding is that there wasn't.

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Q. Is it possible that there was a staff model HMO and you weren't aware of it?
MR. COCO: Objection.
A. No.
Q. So, you're absolutely certain that there was no staff model HMO, and anyone who testified to the contrary is wrong?
MR. COCO: Objection.
A. They have reason to obviously give you testimony based on what they know. If you're asking me if Bay State had a staff model HMO, to the best of my knowledge, the answer is no.
Q. Now, did BCBS of Massachusetts acquire Bay State Health Care -- well, withdraw that. Are you familiar with an entity called "Bay State Health System"?
A. Yes.
Q. Okay.
A. No relation.
Q. What is Bay State Health System?
A. Bay State Health System is a health system in western Massachusetts -- Springfield --

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A. Well, AWP is the price determined -- set by the manufacturer. So, if that's -- if that's the rate -- I don't know if that's the rate Medicare uses or not, but that's the rate that we used as the industry reimbursement.
Q. No, I understand that. My question is why?
A. Why?
Q. Why was it a hundred percent of AWP and then 95 percent --
A. Oh. Okay.
Q. -- of AWP versus something else?
A. Oh, I understand. Well, I think, again, AWP being a -- for lack of a better word -- set by the manufacturer, so, let's call that 100 percent of charge, if you will. And so, again, I think, as I've been involved in physician reimbursement, I think we had a general understanding that that number was largely inflated. And so, we could take a percentage off and negotiate it like we negotiate other numbers.
Q. Now, for as long as you've been involved

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in reimbursement, you understood that number was largely inflated. What did you -- what do you mean when you say, "largely inflated"?
A. I think it was known in the -- again, in my dealings with physicians and my understanding of physician reimbursement -- that the average wholesale price is much like a sticker price of a car, much like the charges in a hospital. It's a price with which you start. And again, it's an industry benchmark, and we go from there.
Q. And that's been known in the industry for a long time, right?
MR. COCO: Objection.
A. Well, I would say it's been -- AWP, as the reference point, has been known. I don't think the health plan -- I can't speak for everybody else. Blue Cross, I think, understood that AWP was -- it was a pricing model set by the manufacturer. I don't -- and, again, how we then reimburse physicians off of that, again, there were some -- there was some level of discounting that could be attained. At what level and how and

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-- I think as we started to hear from physicians, I think we then understood what that meant.
Q. Okay. I think my question was a little unclear. Let me try and rephrase it. We talked about the fact that, you know, it's well known that AWP is a sticker price and that it's an inflated number. The question is, how long has that been well known?
MR. COCO: Objection.
A. Well, again, I don't know what you mean by "well known." When I say it's a sticker price, what I'm saying is that AWP is a number that is pegged to the price of a drug; that AWP pricing is not -- again, that's not what we're reimbursing. We then -- again, my involvement in the fee schedule, my assumption would be that there is some -- there is some relation between the average wholesale price and the cost that we would then end up paying. There has to be a relation, similar to what we talked about earlier when we discount fee schedules. It's based on something, whether it's Medicare -- in this instance, it's

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AWP.
Q. Okay.
A. So, did we know -- did I know that AWP was a standard -- a basis of comparison? Yes. I don't know for how long.
Q. Okay.
A. You know.
Q. Well, you said that since you started in the provider reimbursement area it's been known that AWP is an inflated number, right?
MR. COCO: Objection.
A. AWP -- that's my term, yeah. AWP essentially is set by the manufacturer, and that number, again, when I'm saying, "inflated," I'm saying, "inflated" in relation to how that price then gets passed to a physician and how the physician then bills.
We talked earlier, I think, today about conversation of margin. And so, typically, my conversations with physicians on margin have been exactly on that point.
Q. Okay. So, to use your sticker price

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cost and the AWP or anything else?
MR. COCO: Objection.
A. No. What I'm saying is that --
Q. I'm sorry. Let me just focus my question.
A. Yeah.
Q. My question is, do you have a specific understanding as to a specific number that is the relationship between physicians' acquisition cost for drugs and the rate at which Blue Cross Blue Shield of Massachusetts reimburses? Do you have a specific understanding as to that point?
MR. COCO: Objection.
A. Specific, no. Reasonable, yes.
Q. Okay. And what --
A. Reasonable is not a, number but I would assume it to be reasonable.
Q. What's reasonable?
MR. COCO: Objection.
A. I couldn't give you a number. I don't know a -- reasonable number?
Q. Okay. Well, what do you mean when you

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use the term "reasonable"?
MR. COCO: Objection.
A. Reasonable.
Q. Well, what would be reasonable and what would be unreasonable?
MR. COCO: Objection.
A. I'm not -- I don't have a particular number in my mind. I'm not going to give you a number, because I would not know what a reasonable specific number would be. I would know something that was unreasonable. I can't tell you reasonable. Are double digits unreasonable or reasonable? I don't know.
Q. And if I were to identify a specific number, would you -- would you say that well, there's no way you can peg it to a specific number, that's just unreasonable?
MR. COCO: Objection.
A. Yes.
Q. So, if I were to say, well, would you expect it to be 20 percent, 30 percent, 40 percent, 50 percent, you would say that's

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unreasonable, and there's no way you can put a specific number on what I expect it to be?
MR. COCO: Objection.
A. Again, I'd just go back to that I would expect it to be reasonable. I'm not going to put any number parameters around it.
MR. NOTARGIACOMO: Take a break.
Q. Well, my question was, would you say that I'm being unreasonable if I say the number should be 20, 30, 40, or 50 percent relationship between acquisition and AWP? Would you say that that's unreasonable, and there's no way to peg a specific number to that? Would you say that?
MR. COCO: Objection.
A. Well, I'm not going to -- I'm not going to get into what your -- I'm not going to agree or disagree with that again.
Q. Well, I'm asking you, do you agree with it or do you disagree with it?
MR. COCO: Objection.
A. I have no opinion on it.
Q. My question is, if I were to say that

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you expect there to be a relationship between acquisition and AWP -- that's 20 percent, 30 percent, 40 percent, 50 percent, a specific number -- would that be true or would that be untrue?
MR. COCO: Objection.
A. I would expect there to be a reasonable --
Q. No. My question is, would it be true or would it be untrue?
MR. COCO: Objection. It's not a true-or-false question.
MR. MANGI: It is.
Q. I understand you expect it to be a reasonable number. My question is, if I were to try and say, Well, by "reasonable" you mean this specific number, would you agree with that or disagree with that?
A. I wouldn't --
MR. COCO: Objection.
A. I would neither agree nor disagree, because what I'm trying to tell you is that it would be reasonable. I have no preconceived

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notion of what reasonable is. I am not going to give you a number, because I don't have one in my mind.

MR. MANGI: We can take a break now.

(Recess was taken.)

Q. Now, Mr. Fox, during the break I had an opportunity to review the section of the transcript, and I'd like to ask you about an answer you gave previously.

A. Sure.

Q. I asked you what you mean when you say AWP is inflated. And your answer was, "But that potentially is not -- is not accurate in relation to the price they pay and the price we pay them." And you said that you've had really specific instances where you've talked to physicians about that.

What are the specific instances you were referring to there?

MR. COCO: Objection.

A. I'm talking about -- again, not related specifically to AWP, okay. So, I mean, I've

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talked to physicians about the -- yeah, we went back -- you talked earlier about, you know, reimbursement rates and charge-based -- physicians have charges and we reimburse. And so, I think in general, it's just trying to understand the relationship between what is charged and what is reimbursed. And again, so, then I think we're having the conversation about AWP.

Q. Well, again, let's go back to your previous answer. When you said that, "AWP potentially is not accurate in relation to the price they pay," physicians pay --

A. Physicians.

Q. -- how do you know that?

MR. COCO: Objection.

A. How do I know that? Physicians -- just conversations I've had with physicians. Again, we reimburse, and we expect a fair and reasonable reimbursement, so --

Q. How long -- when's the first -- well, withdraw that. When's the first of these conversations with physicians you recall that led

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you to understand AWP is not accurate in relation to the price physicians pay?

A. There's no specific instance that I --

MR. COCO: I'm sorry. Objection.

THE WITNESS: Sure.

A. There's no specific instance. Again, I -- you know, we go back in time, and you know, I recall having conversations. I can't tell you with who or when. But, again, just try to under -- as I -- just wanting to understand more about the reimbursement side. Again, the pharmacy reimbursement or the medical drug in this instance that we're talking about is a real small piece of the overall reimbursement pie that I deal with.

Q. How long have you known that AWP is not accurate in relation to the price physicians pay to acquire drugs?

MR. COCO: Objection. Misstates previous testimony.

MR. MANGI: I'm actually reading from his testimony.

MR. COCO: When you had read it before,

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you had read that "AWP potentially is not accurate," and now you're taking out the word "potentially."

MR. MANGI: "But that potentially is not -- is not accurate in relation to the price they pay." That's the sentence I'm reading from. My question is a simple one. When you say it's not accurate in relation to the price they pay, how long have you known that?

MR. COCO: Objection.

A. Well, rather than me -- I guess then what I'll say is that obviously the word that I'm using is not -- I'm not using it in that context. And so, as you're playing back what I'm saying, maybe I was going too fast --

THE WITNESS: As you suggested --

A. -- but my point that I was trying to make, and if I change the word, since there's so much focus on it, AWP is a point of reference, and I guess what I'm trying to say is that I understand that to be a point of reference. I'm understanding that there is a difference between

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broker, customer.
Q. Okay. Who do you understand to be Blue Cross Blue Shield of Massachusetts' customers?
A. Accounts --
MR. COCO: Objection.
A. -- brokers.
Q. Okay. What sort of entities are you thinking of when you say, "accounts"?
A. I'm not thinking of any particular account.
Q. Okay.
A. I'm just thinking of accounts in general.
Q. Let me rephrase the question. Are employers -- companies that employ individuals -- clients of Blue Cross Blue Shield of Massachusetts?
A. I would agree with that definition.
Q. Similarly, then do the clients of Blue Cross Blue Shield of Massachusetts include health and welfare funds?
A. They should.

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Q. Unions?
A. Anyone who's contracted with us for services could include any of those.
Q. Now, when -- let's take -- let's take a specific example. Are you familiar with the Pipe Fitters Local 537 Trust Fund?
A. Not specifically.
Q. Okay. But you're aware that that's one of the trust funds -- one of the types of entities we're talking about? Are you familiar with the entity?
A. (Witness nods.)
MR. COCO: Objection.
Q. Never heard of it?
A. No.
Q. Okay. Well, let's talk about any generic health and welfare fund then. Let's call it Customer X. When Customer X, a health and welfare fund, comes to Blue Cross Blue Shield of Massachusetts seeking to obtain coverage for its members, does it enter into a contract with Blue Cross Blue Shield of Massachusetts?

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A. I'm not -- I'm not on the sales side of the house, but that's -- my understanding is that they do.
Q. Do the clients of Blue Cross Blue Shield of Massachusetts, by contracting with Blue Cross Blue Shield of Massachusetts, then get access to Blue Cross Blue Shield of Massachusetts' provider networks?
A. Yes.
Q. Do any of Blue Cross Blue Shield of Massachusetts' clients have their own networks?
A. I'm not aware that this exists.
Q. So, as far as you know, all of them use networks provided by Blue Cross Blue Shield of Massachusetts?
A. As far as I'm aware, yes.
Q. The terms -- because they're using Blue Cross Blue Shield of Massachusetts' network, the terms of reimbursement are then determined by what's been agreed between Blue Cross Blue Shield of Massachusetts and the provider, right?
MR. COCO: Objection.

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A. Repeat this -- just repeat the question.
Q. Sure. Well, when a client comes to Blue Cross Blue Shield of Massachusetts -- a health and welfare fund, for example -- they enter into a contract with Blue Cross Blue Shield of Massachusetts that gets them access to Blue Cross Blue Shield of Massachusetts' provider network, right?
A. That's correct.
Q. Now, Blue Cross Blue Shield's contract with the providers, the contract that sets out the network, that provides for what the payment terms to the provider will be, right?
MR. COCO: Objection.
A. Our contract with our provider sets the payment terms.
Q. So, Blue Cross Blue Shield of Massachusetts' clients are not directly involved in negotiating the amount that will be paid to the provider in reimbursement, is that correct?
MR. COCO: Objection.
A. They -- they may not be directly, but

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they -- we are -- in our role, we are actually -- the whole point of entering into those negotiations and the whole point of those reimbursements is essentially to pass on any of those savings to our accounts.
Q. You're acting on behalf of your clients in contracting with the providers.
MR. COCO: Objection.
A. That's correct.
Q. Are you familiar with the Teamsters?
A. I know who they are.
Q. All right.
A. I know they're an account.
Q. Are you aware that Teamsters Local Health and Welfare Fund are clients of Blue Cross Blue Shield of Massachusetts?
A. Yes, I am.
Q. The facts that we just discussed in terms of the networks of relationships, those apply, I believe, to the Teamsters, that's one example of the type of customer that would have these relationships?

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MR. COCO: Objection.
A. I can't speak to the Teamsters' contract with us, I -- again, at a high level, our networks are available to our accounts.
Q. I use Teamsters as an example of one of the types of funds we've been talking about.
MR. COCO: Objection.
Q. Now, other than Blue Cross Blue Shield of Massachusetts, are there any other entities that have their own provider networks in Massachusetts?
A. Are there other entities? Other health plans?
Q. More broadly, any other entities you're aware of that have their own networks of providers.
A. Well, I mean, "network" is a pretty broad term. Pharmacies have a network of pharmacies, chains --
Q. I'm talking about networks of providers, of physicians.
A. I don't -- I mean, I just don't think I

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understand what your question is.
Q. Blue Cross Blue Shield of Massachusetts has contracts with providers -- has set up a provider network, right?
A. That's correct.
Q. Okay. Other health plans, the CIGNAs, the Fallons, the Neighborhoods, they similarly have their own networks of physicians, right?
A. They have -- they have their own networks. They're largely the same.
Q. Now, other than these entities, the health plans that we've talked about, do you know of any other entities in the marketplace that have networks of contracted physicians in Massachusetts?
A. There may be disease management vendors, but I'm not -- I mean, I'm not aware specifically. I'm not sure what you're thinking of, but I can't think of anything.
Q. Are you aware of any employer plans in Massachusetts, including unions' health and welfare funds, that maintain their own provider

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networks?
A. I'm not aware of any that maintain their own.
Q. Are you aware of any employer plans -- including health and welfare funds -- that negotiate reimbursement rates with physicians directly?
A. I'm not aware of that.
Q. Now, earlier in the day we were running through your employment history at the company, and we got up to the period '95/'96 when you were a network manager. Do you recall the --
A. Yeah.
Q. -- we were talking about that?
A. Yes.
Q. What was your next position after network manager?
A. Would be regional director.
Q. When did you move into that position?
A. It was probably -- probably right after that, '97.
Q. How long did you stay in that position?

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A. I would say '97 to 2000.
Q. What were your responsibilities as a regional director?
A. Just -- I mean --
Q. I'm sorry. Withdraw that for a second. Was that a regional director in a particular department?
A. Regional director of provider relations.
Q. Okay. Now, what were your responsibilities in that position?
A. The responsibilities were to coordinate the activities of staff and essentially -- it becomes largely an internally-based role, versus in the previous roles, which are more externally-based. You get more involved in management and administration and representing kind of a particular region, and just -- instead of having a knowledge or relationship of a particular group of providers, you become knowledgeable around a larger group, more at a regional level.
Q. Were you still dealing directly with provider groups?

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A. Sure. I maintained some relations out there, but -- yeah.
Q. Was that a smaller proportion of your time than it had been previously?
A. Yes. Yes. Definitely.
Q. What proportion of your time was spent in direct contact?
A. Probably less than 25 percent.
Q. Now, after the regional director stint from '97 through 2000, what was your next position?
A. Director.
Q. Director of provider relations?
A. Director of provider relations, and then I took on communications as well.
Q. How long was your title just director of provider relations?
A. It wasn't. It was when I took on the director of provider relations, with that came the other department, which was a separate department.
Q. And remind me, what was the full title?
A. At that time it was provider relations

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and communications.
Q. Okay. So, how long was your title, director of provider relations and communications?
A. Till a year ago, February of 2005.
Q. And what did it change to in February of '05?
A. Senior director of provider relations, communications, and eHealth.
Q. Now, is provider relations and communications the same thing, or is it two separate tasks in that title?
A. It's two different departments.
Q. Okay. What's the function of provider relations, and what's the function of provider communications?
A. Provider relations is responsible for the external administrative relationships. I think I may have mentioned -- I mentioned in my other -- earlier we talked about the role. It's working with physicians, doing a lot of education, training, you know, helping them to understand how to work with the plan. It also is involved in

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implementing contracts that were executed under -- you know, so physicians knew what the terms were, etcetera.
The communications side of -- is communications strategy. All of the external provider communications that the Plan produces come out of this shop, all the newsletters, organization of meetings, things like that.
Q. In the communications role, does that focus on communications from BCBS to physicians, as opposed to the communications?
A. Correct.
Q. Okay. So, the focus is on mailings and things like that which are being sent out to physicians?
A. That's correct.
Q. Insofar as this communication going the other way from the physician to BCBS of Massachusetts, that would be part of the provider relations department rather than provider communications department?
A. That's accurate.

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A. Our -- again, my knowledge would be the AWP price, and in a -- and can go on from there. You're introducing a term that I'm not familiar with around this WAC.
Q. Let me ask you --
A. So --
Q. -- to then simply understand that the actual acquisition costs are 30 percent below the AWP --
A. Uh-huh.
Q. -- for Remicade, and that that number, the acquisition price, is actually publicly available. It's published.
A. Uh-huh.
Q. In that situation, is Centocor committing fraud, in your opinion?
MR. COCO: Objection.
A. I'm not a lawyer. I can just tell you that we expect fair and reasonable reimbursement.
Q. Okay. Expecting --
MR. COCO: Again --
Q. I'm sorry. I thought you were done.

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Are you not?
MR. COCO: Adeel, let me complete my sentence as well. The record doesn't reflect it, but there are times when you start getting on a roll with your questions, and you are cutting off the witness before he has completed a sentence --
MR. MANGI: I strongly disagree with that, but I'm happy to wait for the witness to complete his answer.
MR. COCO: And you just did it now.
MR. MANGI: I did it to you, but I haven't done it to the witness.
MR. COCO: For the record, I would just ask that you pause to make sure that the witness is done completing his answer before you proceed to the next question.
MR. MANGI: That's fine. I interpreted from the witness's pause that he was done. If he wasn't done, I apologize.
Q. Were you done?
A. The point I was going to finish with is, separate and apart from numbers which are, you

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know, is this reasonable, is this not reasonable, this is a business that we're in where 1 percent margin, 2 percent margin that people are making is make or break between staying in business and going out of business. So, in that context, again, what's reasonable? Reasonable is in the eyes of beholder. And in the context of drug or drug prices, I don't know if that's reasonable or not. I'm not qualified to make a determination in my role as director on the reasonableness of that question.
Q. Do you personally, as the director of provider relations, feel misled about anything Centocor did around the pricing of Remicade?
MR. COCO: Objection.
A. If you're asking me personally, a 30 percent differential would not seem to be reasonable. Again, 1 to 2 percent, 3 percent margins that we're talking about in the business that we're in is different than a double-digit.
Q. Now, so -- and a double-digit margin you're saying would be unreasonable whereas 1, 2,

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3, 4 percent would be reasonable?
MR. COCO: Objection.
A. I'm not going to qualify it. I'm just -- - in the example that you're using, given the difference in the pricing that you're talking about, that, again, I don't have direct knowledge of, just answering your assumptions.
Q. Are you aware that the position you just stated is flatly inconsistent with the position that the Plaintiffs', Blue Cross Blue Shield of Massachusetts, and others have taken in this litigation? Are you aware of that fact.
MR. COCO: Objection.
A. I would have no knowledge of what's in the --
Q. Are you aware that the Plaintiffs in the litigation --
MR. COCO: Again, he did not finish.
MR. MANGI: He was clearly done with that answer.
Q. Were you -- did you have something more to say?

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A. What year are you referring to?
Q. Well, for what period of time was it the carrier, as far as you know?
A. 1967? I mean, Medicare was formed in 1967. We've been working with Medicare -- I mean, that's what I'm saying is we were a carrier in the '80s, you know, early '90s. But I don't know who was responsible for it. It was not my area. It was a different division.
Q. Do you know when BCBS of Massachusetts ceased to be a Medicare carrier for Massachusetts?
A. Sometime in the '90s. I don't remember exactly when it was.
Q. Do you know of any current employees at BCBS of Massachusetts who did have responsibility for work on the carrier side of the business?
A. No.
Q. Do you know of any former employees who had responsibility for that side of the business?
A. No.
Q. Are you aware that Blue Cross Blue Shield of Massachusetts had a staff model HMO at a

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point in time?
A. Yes.
Q. That was called Medical East Medical West, right?
A. Yes.
Q. For what period of time did BCBS of Massachusetts have that staff model HMO?
A. I don't know how long. Again, I came on board when the staff models were in existence. They were in existence from the '80s.
Q. When?
A. I don't know specific years and dates.
Q. When did BCBS of Massachusetts cease to have a staff model HMO?
A. That was -- we spun off the health centers as a separate corporation probably around 19 -- well, it's ten years. So, it's 1996, probably 1997.
Q. Do you know who at BCBS of Massachusetts, be it current or former employee, would be knowledgeable as to how and/or what prices staff model HMO acquired drugs?

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A. I would have no idea.
Q. Do you know whether or not Blue Cross Blue Shield of Massachusetts contracts with drug manufacturers for rebates pertaining to formulary replacement?
A. Manufacturers?
Q. Yeah.
A. We have a pharmacy benefit manager that does our contracting, but --
Q. Okay. Is that Express Script?
A. That's correct.
Q. Does ESI contract on BCBS of Massachusetts' behalf with manufacturers for rebates?
MR. COCO: Objection.
A. I have no idea what their relationship is or what they do.
Q. Okay. Do you know whether or not, directly or indirectly, BCBS does contract with manufacturers for formulary rebates?
MR. COCO: Objection.
A. Again, we don't contract with

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manufacturers, so I wouldn't have any of that knowledge. We contract with Express Scripts. I don't know what Express Scripts does.
Q. Okay. How many employees does BCBS of Massachusetts currently have?
A. Employees?
Q. Uh-huh. Do you know how many people make up the organization?
A. Over 3,000.
Q. Do you know how many employees worked on the carrier business before it was spun off?
A. No idea.
Q. Do you know whether it was a handful of people or dozens of people?
A. I have no frame of reference. Again, had little to no involvement with that side of our business.
MR. MANGI: Let's mark the next document.
(Group Primary Care Physician Agreement marked Exhibit Fox 012.)
Q. Now, Exhibit Fox 012 is a boilerplate

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contract template, right?
A. Yes.
Q. Now, this particular template says, "Entered into between BCBS --" then there are some more words there "-- on behalf of the Plan's HMO Blue products." Do you see that?
A. Yeah.
Q. Now, were there different templates for different products?
A. Yes.
Q. And how many products does BCBS have in total?
A. I don't know how many products. There are 16 different templates.
Q. There are 16 different templates in existence at the present time?
A. There's probably more than that, but the boilerplate -- 16 boilerplates. Again, largely the same, just different between primary care physicians and specialists, group versus individual, PPO, HMO, indemnity products.
Q. How often do those boilerplates change?

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A. Not frequent.
Q. When you say 16 templates, are you including within that hospital templates?
A. No, just physician.
Q. Just physicians?
MR. MANGI: For the record, we called for the production of 16 templates. We've only received about five.
Q. I'd like you to -- by the way, I asked you earlier -- perhaps you can remind me -- there's only network correct BCBS only has one physician network?
A. I would classify, again, one network.
Q. Turn to clause -- the Section 2.3 of that contract, please. It's on Pages 5 and 6.
A. Uh-huh.
Q. Now, I'd like you to turn over to Page 6, and I'm looking at the last ten sentences of that clause, "Moreover, the group understands and accepts that some or all of the new offerings may involve limited networks."
A. Right.

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Q. What are limited networks?
A. It means in the future we could decide to offer -- a product could be developed that did not require all physicians participating in a given network. So, this boilerplate contemplates the future product offerings.
Q. And has a limited network ever been developed, to your knowledge?
A. No, it has not.
Q. Turn to Section 1.9, please. Page 2.
A. And just for the last point, since you made the reference about the number of boilerplates, the reason that you don't is because the recent changes in Medicare Advantage laws required us to create separate boilerplates for our Medicare business. So, several templates are Medicare Advantage, so, just --
Q. Are those included within the 16?
A. Yes.
Q. How long have there been 16 standard templates?
A. Probably just fairly recently. Fairly

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recently.
Q. Last three years?
A. Last two years, yeah.
Q. How many templates were there in existence before that time?
A. There should just be -- boilerplates? It's largely -- it's this same language, just with different headers. It should be one, two, three -- there should really be four. Again, if you want to say that HMO Blue products, PPO products, and indemnity products are different then, again, four contracts, but there could just be different words at the top. But true boilerplates, there's really only four. The additional ones are really recent. So, I'm sorry. You were asking me to look at what section now?
Q. Actually, I may be able to short-circuit that. I'm asking you to turn to 4.15.
A. 4. what?
Q. 4.15 on Page 6.
A. Okay. Yeah.
Q. Now, this clause describes two types of

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compensation available to physicians.
A. Uh-huh.
Q. There is the Fee For Service, and then the Member Management Fee program, right?
A. Uh-huh, yes.
Q. Now, the Fee For Service compensation is based on the lesser of the physician's charges or the amount listed in the fee schedule, minus any applicable copayment, right?
A. Yes.
Q. Okay. Now, in what percentage of cases are the physicians' bill charges lower than the amount on the fee schedule?
A. Physicians' billed charges lower than the fee schedule? I'm not aware of specific examples. We have 26,000 physicians in our network.
Q. Okay. Well, let me ask you to take a look at Clause 1.19, which is on Page 4 in connection with what we were talking about.
A. Uh-huh.
Q. It says -- it defines physician payment

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benefit as, "The lesser of the charge for the covered service or the amount listed on the fee schedule," right?
A. Uh-huh.
Q. Now, how long has that lesser-of methodology been used in BCBS of Massachusetts contracts?
A. I don't know how long. I mean, it's -- I don't know specifically.
Q. If I wanted to look at claims data, for example, and figure out which claims were paid at the fee schedule rate, which ones were paid at the bill charge, how would I know which is which?
A. You wouldn't. You -- I mean, you wouldn't.
Q. So, there would be no way for me to figure that out?
A. No way that I --
MR. COCO: Objection.
A. No.
Q. Now, if you turn to Clause 4.15.4, please, which is on Page 17.

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A. Uh-huh.
Q. This clause provides for 90 days written notice, right?
A. Yes.
Q. Okay. Now, other than the annual updates that we spoke about earlier, how often are fee schedules revised, in part or in total?
A. Once a year.
Q. So, the annual update is the only revision.
A. Yes.
Q. Now, and that update incorporates any negotiated variations, as well as any overall increases in reimbursement, right?
MR. COCO: Objection.
A. I mean, this is standard language in all of our agreements. So, there, again, this is an evergreen contract. There is no start and stop date to this. So, if we enter into a negotiation, they may have different dates and terms, but the language would be the same.
Q. What happens if a provider disagrees

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with a change made by BCBS of Massachusetts to the fee schedule?
A. What happens if they disagree? I suppose they could let us know. If they don't, they could terminate their contract if they were that aggrieved by our rates.
Q. Now, sticking with this Section 4.15, we looked earlier at the Member Management Fee program, right?
A. Uh-huh.
Q. And that's described further at Appendix B to the contract --
A. Uh-huh.
Q. -- which is at Page 34 of the document. Do you see that?
A. Yeah.
Q. Now, are you generally familiar with the Member Management Fee program?
A. Yes.
Q. Okay. Describe it for me. What is that program?
A. It is an incentive program that is in

# EXHIBIT 12

UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF MASSACHUSETTS

MDL No. 1456

C.A. No. 01-CV-12257-PBS

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IN RE: PHARMACEUTICAL INDUSTRY *
AVERAGE WHOLESALE PRICE LITIGATION *
_____ *
THIS DOCUMENT RELATES TO ALL ACTIONS *

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VOLUME I

DEPOSITION OF JAN L. COOK, M.D., a witness called on behalf of Johnson & Johnson, pursuant to the Federal Rules of Civil Procedure, before Jessica L. Williamson, Registered Merit Reporter, Certified Realtime Reporter and Notary Public in and for the Commonwealth of Massachusetts, at the Offices of Robins, Kaplan, Miller & Ciresi L.L.P., 800 Boylston Street, Boston, Massachusetts, on Wednesday, March 6, 2006, commencing at 9:37 a.m.

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Q. Now, in 2000 what positions did you move to?
A. Quality medical director, Blue Cross/Blue Shield of Massachusetts.
Q. Was that a part-time position also?
A. Correct.
Q. Were you working anywhere else at that time?
A. No.
Q. And how long did you remain the quality medical director?
A. For a year.
Q. And how about in that position, what responsibilities did you have?
A. Responsible for the clinical quality department, Blue Cross/Blue Shield of Massachusetts.
Q. What does the clinical quality department do?
A. Design programs to help the company become in compliance with NCQA accreditation, the URAC accreditation.

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Q. What is NCQA?
A. National Committee for Quality Assurance.
Q. Is this a position related to credentialing?
A. No. Credentialing is one of the standard -- but this was more managed care organizations. It's sort of like the good seal of, you know, housekeeping -- showing my age -- of approval but it's like our J codes for hospitals, joint commission for hospitals. It's essentially our accreditation by that says that the managed care company was doing everything they should, and I was responsible for the elements related to clinical quality.
Q. So that brings us up to about 2001; correct?
A. Correct.
Q. What position did you move to at that time?
A. Regional medical director.
Q. Now, what were your responsibilities in

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that position?
A. To support provider contracting, provider services at Blue Cross/Blue Shield of Massachusetts, and initially in the northern part of the state.
Q. How long did you hold that position?
A. I'm still in that position.
Q. Your title has not changed?
A. Not really, no. Regional medical director.
Q. Have the areas of the country for which you have responsibility changed?
A. Correct. So I'm now responsible for the central and western part of the state.
Q. When did that change occur?
A. I think 2002, 2003. I'm not quite -- I don't quite remember when exactly.
Q. And you've been employed in that position continuously from 2001 till the present time?
A. Correct.
Q. Are you still a part-time employee?

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A. Correct.
Q. And you've been part time throughout that period of time?
A. Correct.
Q. But throughout that period of time this is the only position you've been working in, you haven't also had another job; is that correct?
A. Correct.
Q. Let me show you a document, and we'll mark this as Exhibit Cook 001?
(Exhibit Cook 001, Document Bates-numbered BCBSMA-AWP-12120 - 12146, marked for identification.)
Q. Now, if you could turn to the second page of that document, which is the BC/BS organization page?
A. Okay.
Q. Is this the current -- does this reflect the current structure of the organization?
A. No.
Q. Okay. How has the organization changed?
A. Well, the chairman and chief executive

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relationship between the price at which they acquire drugs and the amounts they reimburse, if any?
MR. COCO: Objection.
A. I'm only aware of what our payment policy is. I'm not aware of what people in general are paying for their drugs.
Q. So is the answer to my question that you have no understanding or expectation as to the relationship between the price that they pay to acquire drugs and the amount that they're reimbursed for drugs?
MR. COCO: Objection.
A. Yeah.
Q. Now, let me mark a document. This will be Exhibit Cook 002.
(Exhibit Cook 002, Document Bates-numbered BCBSMA-AWP-12489 - 12492, marked for identification.)
(Discussion off the record.)
Q. Now, there are a number of e-mails on this chain. I'll draw your attention to specific

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parts of them, but please take your time to familiarize yourself and let me know when you're ready.
(Witness reviews document.)
MR. MANGI: Off the record.
(Discussion off the record.)
MR. MANGI: Okay. Back on the record.
Q. I would like to draw your attention first to the last e-mail in the chain which starts on Page 12493. Do you have that?
A. Yes.
Q. Now, this e-mail that is sent to you from vdulong@mms.org?
A. Uh-huh.
Q. Who is that?
A. That's Virginia or Ginny Dulong at the Mass. Medical Society.
Q. What is your relationship between the Mass. Medical Society and MASCO, if any?
A. I don't know what the, like, official -- I mean, if they're part of the organization or the Massachusetts Medical Society offers them support.

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Ginny at the time in 2002 was sort of like the administration liaison for MASCO. And I am not really sure who employed her, was it the Mass. Medical Society or the group employed her, but...
Q. Now I would like you to turn to -- well, first of all, her e-mail is listing a number of specific issues and seeking an update from you as to where things stand as to those issues, right?
A. Yes.
Q. I would like you the turn to No. 6, please. And the topic is "Inadequate chemo reimbursement:" And the question is, has anyone at BC/BS had a chance to review the articles that Dr. Goldstein provided about inadequate chemotherapy reimbursement? Now, who is Dr. Goldstein?
MR. COCO: I'm sorry, new question? You said my question is this, and then you asked who's Dr. Goldstein? So you just want an answer to who's Dr. Goldstein?
MR. MANGI: I thought that was the only question that I posed.

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Q. But you can answer that. Go ahead.
A. You know, I don't know -- I don't remember this e-mail, so I don't know if that -- offhand I'm thinking is that one of the oncologists? It could have been one of the oncologists -- is there a Michael Goldstein? I can't remember if that's who that is.
Q. Do you know what articles are being referred to?
A. I don't offhand. I don't remember.
Q. Do you recall the Mass. Medical Society or MASCO forwarding you articles from time to time dealing with reimbursement issues generally?
A. No. They generally didn't send articles, and I don't think if -- in this case I look at this and it looks like this was the action items off of a meeting. I wonder if he gave us articles at that meeting. I don't think -- they don't generally send articles to us.
Q. Do you have any recollection as to what these articles were addressing?
A. No, I don't, not offhand, I don't. It's

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been a long time ago.
Q. Let me ask you to turn to the previous page on the next e-mail up, which is your response to Ms. Dulong. And if you have a look at No. 6 there, "Inadequate chemo reimbursement:", your response is "We reimburse as Medicare does AWP minus 5 percent. We understand that in some situations this is very favorable to practitioners and in others it may be less advantageous. In general we feel that this process evens itself out. If this isn't the case, we would be glad to continue to discuss this with you."
Do you recall sending that e-mail?
A. No.
Q. Okay.
A. But it says it was from me, so yes.
Q. Okay. Now, what did you mean when you said you understand that in some situations it's favorable and in others it's less advantageous?
MR. COCO: Objection.
(Witness reviews document.)
A. Well, I'm assuming -- I mean, I don't

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remember writing this e-mail, but if I read it now, I assume what I'm saying is what I said that sometimes it's more favorable to others, then sometimes it's not.
Q. Well, my question is: In what respect is it favorable or not favorable?
MR. COCO: Objection.
A. I think that, you know, not everybody -- and I'm trying to remember that time, and I don't remember clearly, but not everybody gives chemotherapy in their office and that I think that people who -- there's a lot of reasons why people would choose to do that and not choose that. I think that I think at times that if you were giving a lot of medications in your office, that you might be getting some sort of volume discount. Sometimes it was more favorable to you than not because not everybody would do this practice.
Q. Okay. So you were -- withdraw that.
So your understanding was that oncologists who did administer chemo in their offices may be able to get volume discounts that

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would lower their acquisition costs for the drugs; is that correct?
MR. COCO: Objection.
A. I wouldn't tell you that was my understanding, because nobody ever exactly said that to me, but my assumption was that might have been the -- that somehow that why doesn't everybody do this, okay? So my assumption was that somehow somebody was -- something was happening to that effect maybe.
Q. And your assumption was also that the amount of the discount would vary from provider to provider depending in part on their volume of use?
MR. COCO: Objection.
A. Well, I don't think I thought about it that much, but I think what I thought was that you might if you -- I really didn't think about it that much in terms of I think I thought that if you might get something on volume if you did a lot of volume. But I didn't really think, well, you only did -- I mean, nobody ever said to me, Jan, you get X amount when you do X, Y and Z. So I

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have no idea, but I assume that somehow, because some people did it and some people didn't, that they might get something like that.
Q. Well, I'm trying to understand specifically what you mean when you refer to the fact that they may be different situations, you know, less favorable in some, more favorable in others. Were you assuming there that the acquisition cost for drugs would vary from provider to provider, meaning the rates would be more favorable for some providers and less favorable for other providers?
MR. COCO: Objection.
A. I think I was assuming pretty much what I've told you, I mean, that, you know, I think that -- I think that -- you know, pretty much what I told you, that maybe somebody -- some things if you prescribed a lot of medications, that you got a better deal. But I mean, I didn't think a whole lot more about that than that.
Q. Now, could I ask you to turn to the very first page of the exhibit, and turning now to the

# EXHIBIT 13

UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF MASSACHUSETTS

MDL No. 1456

C.A. No. 01-CV-12257-PBS

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IN RE: PHARMACEUTICAL INDUSTRY *
AVERAGE WHOLESALE PRICE LITIGATION *
_____ *
THIS DOCUMENT RELATES TO ALL ACTIONS *

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VOLUME I

DEPOSITION OF LISA M. GORMAN, a witness called on behalf of Johnson & Johnson, pursuant to the Federal Rules of Civil Procedure, before Jessica L. Williamson, Registered Merit Reporter, Certified Realtime Reporter and Notary Public in and for the Commonwealth of Massachusetts, at the Offices of Robins, Kaplan, Miller & Ciresi L.L.P., 800 Boylston Street, Boston, Massachusetts, on Tuesday, March 7, 2006, commencing at 9:00 a.m.

EXHIBITS (CONTINUED)



Note: Original Gorman Exhibits 1 - 9 were retained by the court reporter and forwarded to Henderson Legal Services, Inc. for distribution.



PROCEEDINGS

LISA M.GORMAN a witness called by counsel for the Johnson & Johnson, being first duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. MANGI:

Q. Good morning, Ms. Gorman.
A. Good morning.
Q. As I mentioned when we met, my name's Adeel Mangi. I represent Johnson & Johnson in this litigation. Have you ever been deposed before?
A. No.
Q. Okay. I'll just run through some of the basics of the deposition.
A. Okay.
Q. If I ask you any questions that are unclear, please just tell me that, and I'll do my best to rephrase them, okay?
A. (No verbal response.)



Q. You also need to answer all questions verbally, because the reporter can't take down a nod of the head or a shrug of the shoulders, okay?
A. Okay.
Q. And if at any point you would like to take a break, just let me know. I'll finish the line of questioning and we'll do that, okay?
A. Okay.
Q. Now, are you currently employed?
A. Yes.
Q. Where are you employed?
A. At Blue Cross/Blue Shield of Massachusetts.
Q. What is your current title?
A. My current title is regional director of the metro north provider relations team.
Q. What regions does metro north cover?
A. Metro north covers half of Boston, all physicians and hospitals north of Boston all the way over to the center of the state.
Q. Does it include any parts of Boston itself?



A. South of Boston?
Q. No, does it include Boston itself?
A. Yes.
Q. Okay. So it's the north part of Boston --
A. Yes.
Q. -- as well as everything to the center of the state?
A. Yes.
Q. Is that a -- forgive my lack of geography, but is that a mix of rural and urban areas?
A. Yes.
MR. COCO: I'm sorry. Is there truly anything rural in the northeast?
MR. MANGI: Massachusetts.
MR. COCO: Just Massachusetts.
MR. MANGI: I'm from Jersey. You should try that.
Q. Now, can you please describe for me your educational background after high school.
A. After high school, I graduated from

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Q. Okay. Now, earlier in the day you also testified that you don't know as a general matter what exactly physicians paid to acquire drugs, right?
A. Yes. It's not part of my job responsibility.
Q. Okay. So you do have an understanding here that different doctors may have paid different rates, but your testimony is that you don't know what the rates are that any doctors pay to acquire drugs?
A. That's true, yeah.
Q. So you have no understanding or expectation, then, as to what the relationship is between doctors' acquisition prices for drugs and the amounts that they are reimbursed for drugs?
MR. COCO: Objection.
A. I don't know, no.
Q. So your answer is that you have no such understanding or expectation?
A. I don't, yeah.
MR. MANGI: Let's mark the next

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document. It's going to be Exhibit Gorman 005.
(Exhibit Gorman 005, Document Bates- numbered BCBSMA-AWP-00078 - 00079, marked for identification.)
MR. COCO: It's been about 50 minutes. Does it make sense to break now?
MR. MANGI: Sure, any time you want.
(Recess taken.)
Q. Now, Ms. Gorman during the break, did you have a discussion with counsel?
A. Yes.
Q. Did you have a -- or did you discuss during the break the testimony that you were giving before the break?
A. We -- yes.
Q. Okay. What did you discuss?
A. We just talked about some of the questions that you were asking and some of my responses.
Q. Okay. What did counsel ask about, and what did you respond in relation to the answers you were giving earlier?

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MR. COCO: Objection. And I'll instruct you not to answer.
MR. MANGI: You'll instruct her not to answer that question?
MR. COCO: Yes.
MR. MANGI: On what basis?
MR. COCO: It's attorney/client privilege.
MR. MANGI: No, it's not. It's well established in federal courts around the country and in this district that questions about the substance of examination are not privileged and are the proper scope for examination. Moreover, your firm has a precedent where you have previously recognized that and allowed questioning of that type through your colleague, Mr. Sullivan, at the deposition of Mr. Killion.
MR. COCO: Can we take a break?
MR. MANGI: Sure.
(Recess taken.)
Q. Okay. On the record. May we have the last question read back, please.

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(Record read.)
MR. COCO: Objection. Instruct the witness not to answer.
MR. MANGI: Okay. We'll have to call the magistrate judge. We'll do that at the end of this session when we take a lunch break.
MR. COCO: And for the record, the witness is not changing testimony. The witness is not giving any indication that there was any discussion about changes to the testimony. And if you were simply inquiring as to, you know, generally what attorneys discuss with a witness about the deposition and what's been happening and does not reflect any changes or any alteration of previous testimony, then it is our position that you are not entitled to --
MR. MANGI: I understand your position.
MR. COCO: -- go into those.
BY MR. MANGI:
Q. Now, Ms. Gorman, can you turn to -- oh, you don't have it anymore -- the exhibit that we've marked as Exhibit Gorman 005.

# EXHIBIT 14

UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF MASSACHUSETTS

MDL No. 1456

C.A. No. 01-CV-12257-PBS

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IN RE: PHARMACEUTICAL INDUSTRY *

AVERAGE WHOLESALE PRICE LITIGATION *

_____ *

THIS DOCUMENT RELATES TO ALL ACTIONS *

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VOLUME I

VIDEOTAPED DEPOSITION OF VINCENT D. PLOURDE, a witness called on behalf of Johnson & Johnson, pursuant to the Federal Rules of Civil Procedure, before Jessica L. Williamson, Registered Merit Reporter, Certified Realtime Reporter and Notary Public in and for the Commonwealth of Massachusetts, at the Offices of Robins, Kaplan, Miller & Ciresi L.L.P., 800 Boylston Street, Boston, Massachusetts, on Thursday, April 13, 2006, commencing at 9:35 a.m.

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MR. SKWARA: Steve Skwara, Blue Cross/Blue Shield of Massachusetts.
MR. COCO: Stephen Coco, Robins, Kaplan, Miller & Ciresi, representing Blue Cross/Blue Shield of Massachusetts.

VINCENT D. PLOURDE,
a witness called on behalf of Johnson & Johnson, having first been duly sworn, was deposed and testifies as follows:

DIRECT EXAMINATION
BY MR. MANGI:
Q. Morning, Mr. Plourde.
A. Good morning.
Q. Have you ever been deposed before?
A. I have.
Q. How many times have you been deposed?
A. Once that I can recall.
Q. When was that deposition?
A. I believe it was September of 2004.
Q. What kind of case was that?

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A. I believe it was the Thomas/Solomon case.
Q. You are currently employed by Blue Cross/Blue Shield of Massachusetts, correct?
A. Correct.
Q. What is your title?
A. Vice president of the provider services division.
Q. How long have you held that position?
A. Since 2002.
Q. Your deposition in the Thomas litigation, was that a one-day deposition?
A. It was.
Q. What's your understanding as to what that litigation was about?
A. It was about some alleged improprieties that were believed to have taken place between Blue plans and limiting information that was accessible to providers.
Q. What sort of improprieties and limiting information are you aware of?
MR. COCO: Objection.
A. I'm sorry, what type of --

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Q. Let me rephrase the question. In terms of the allegations that you've just mentioned --
A. Yeah.
Q. -- what specifically was being alleged in terms of improprieties or ways of limiting information?
A. What was -- what was asked of me?
Q. Or your general understanding of what the case was about.
A. I think it was generally around physicians not knowing how exactly specific edits are applied to claims processing. I think that was the general gist, that there was -- they were unaware of information that was being used to make claim payment decisions.
Q. Anything else that you're aware of that was at issue in that case?
A. There was concern about the kinds of disclosures of information to physicians around those claim edits, and I think there were -- I'm trying to think -- again, just general disclosures of information, were providers aware that there were

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edits applied to claims processing?
Q. Was one of the issues in that case disclosure of the actual rates at which reimbursement is made, fee schedules and such, as opposed to edits that are made to the designated rates?
A. I'm not sure I understand your question.
Q. You're aware that there are fee schedules and base payment for providers that are in fee-for-service --
A. Correct.
Q. -- contracts, right?
A. (No verbal response.)
Q. Was one of the issues in the Thomas litigation whether or not those fee schedules were given to providers?
A. I believe that may have been part of the issue, yes.
Q. Was that an issue that you were questioned on at your deposition?
A. No.
Q. Do you have an understanding as to whether

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When we brought pricing files over, it's not like we took the Blue Shield pricing files and necessarily melded them with the Blue Cross pricing files. It's simply a separate table. So whatever Blue Shield provider rates that were in effect before were housed in one part of the system and whatever Blue Cross rates that were in effect were housed in a different part of the system, but it didn't -- there wasn't an activity to take a professional rate and meld it with the Blue Cross system to come up with a new melded rate.

Q. At some point thereafter, after that initial process of bringing all the rates into one system had been complete, did such a process take place of combining them to arrive at one set of payment rates?

A. I would have to say no. I mean, we today still -- it's a -- we paid based on a number of different arrangements. We pay fee-for- service, we pay I'm sure in some select arrangements charges, we pay payment on account factor. So we use all of those different variables. We pay DRG, we pay per

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diem.

Q. There's no -- there's no distinction today between Blue Cross rates and Blue Shield rates in the system, right?

A. There are -- there are -- no, there are inpatient and outpatient payment on account factors --

Q. Right.

A. -- that are employed. And to answer your question, I honestly can't tell you whether or not -- whether or not I would presume that if the same service were rendered in a hospital versus in an outpatient clinic, that those in fact -- I mean, in a physician's office, that those services in fact wouldn't be paid the same rates because they're two different settings.

Q. I didn't quite follow your last -- your last statement.

A. I guess I'm trying to clarify the statement that you made or the question that you asked around, you know, these rates somehow being the same. And what I'm saying is I'm not sure that

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if a particular procedure is performed, if that procedure is performed in a hospital versus that same procedure being performed in a physician's office. What I'm saying is my sense is those rates of reimbursement are not the same. There's different overhead in a hospital setting to render care than there is in a physician's office.

Q. I didn't intend to raise that issue, but it's an interesting issue, so let's talk about it a bit. Do I understand correctly the point you are making is that there are different payment rates for hospitals versus physicians' offices in part due to the fact that they have different overheads?

A. Correct. Correct.

Q. Do you have an understanding as to which setting is more expensive to Blue Cross/Blue Shield of Massachusetts?

A. My --

MR. COCO: Objection.

A. My sense, and it would just be to my sense, that intuitively I would think that the services rendered in a hospital setting would be

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more expensive.

Q. And that would include a hospital outpatient department as opposed to a physician clinic?

A. Correct.

Q. Okay. Now, what is the basis for the intuitive understanding? In other words, what makes you think that?

A. The fact that the hospital has much more overhead. They have a staff of nurses, they have hospital beds, they have all kinds of other fixed costs that a physician practicing in an office does not have. Now, whether that's reflected in a payment rate or it's differentiated through some type of, you know, multiplier, I have no idea.

Q. Now, let's turn back to the issue I was trying to address earlier which pertains to the coming together of Blue Cross and Blue Shield systems. I understand that when the merger first took place there were just the different components housed in the same system. Today, however, as we discussed, they're not separate Blue Cross rates

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they would apply these discounts. So if a provider wanted to be part of this net -- of the PCS network, which was the vendor at the time, then they had to accept the terms of that contract.
Q. Now, your Medex time was -- could you remind me what the time period was when you were in charge of Medex?
A. 1991 through 1995.
Q. And when did you outsource some of this work to a PBM?
A. I'm not sure.
Q. Okay.
A. I would -- I would guess 1994.
Q. Do you know which PBM that was?
A. PCS.
Q. Okay. So in the early '90s you understood that PCS could get discounts and rebates on the rates it reimbursed for drugs?
MR. COCO: Objection.
A. Correct.
Q. Did you also understand that PCS could get rebates and discounts on drugs that it purchased,

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say, for its mail order division?
MR. COCO: Objection.
A. I don't have any specific knowledge about their mail order.
Q. Okay. But based on the fact that PCS as a PBM could get discounts and rebates, you also understood that other entities in the market like physicians and hospitals would be able to get discounts and rebates on drugs that they purchased?
MR. COCO: Objection.
A. I don't have any specific knowledge to that.
Q. Okay. Well, earlier you mentioned that when -- that you understand that providers can get discounts and rebates on drugs. I'm trying to understand your basis for that knowledge.
A. The statement I made that PCS, the PBM vendor that we worked with, was able to deliver to us a price less than AWP.
Q. Okay. Do I understand correctly that in that '91 to '95 time period you understood that providers can also get discounts and rebates on

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their drug acquisitions?
MR. COCO: Objection.
A. I do not know. I did not know that they could get, no. I know we got a discount.
Q. Okay. Well, here's what I'm trying to understand. Did I understand correctly your earlier testimony that today, as you sit here now, you do understand that providers can get rebates and discounts on drug purchases?
A. I do.
MR. COCO: Objection.
Q. Okay. How long have you been aware of that fact?
A. Maybe a year.
Q. Okay. How did you come by that knowledge?
A. Just reading information in journals, Web stories, you know.
Q. Okay. What sort of stories or journals are you thinking of?
A. Just the fact that there are these, you know, discounts available.
Q. Now, is it your understanding that the

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discounts and rebates that are available to hospitals and physicians are all -- are uniform, there's a particular discount or a particular rebate available across the board, or do you understand there to be variable rates of discounts and rebates?
A. My understanding would be that there are variable discounts.
Q. Okay. Is it your understanding that those rebates and discounts fall within a particular range or a particular band or that they vary widely?
MR. COCO: Objection.
A. I do not have a particular percentage in mind.
Q. Okay. So you have no particular expectation as to what the range of discounts and rebates would be, although you know that rebates and discounts exist?
A. Correct. Correct.
Q. Are there any particular journals or stories that you've read that you are thinking of?
A. No, just different Web services that I subscribe to, i-Health Beat, different trade

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A. There are some, yes.
Q. Another issue that was discussed in the provider financial strategies work group was transitioning hospital outpatient departments from a percentage of bill charge methodology, and I'm talking now about drugs administered to patients in hospital outpatient departments. My sentence has become long, so let me start the question again.
Another issue that's been discussed in the provider financial strategies work group is transitioning hospital outpatient departments from a reimbursement methodology that uses percentage of bill charge in relation to drugs administered to members to a methodology that uses 95 percent of AWP. Are you familiar with that transition?
A. I have heard that term discussed. I'm not familiar with the outcome.
Q. Okay. When you say, "I've heard that term discussed," what term are you referring to?
A. What you just said, that we -- you know, taking a look at outpatient charges as today being adjudicated at a percent of charges and considering

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whether or not they should be instead reimbursed at some percentage of AWP.
Q. So you were saying that you're familiar with the issue, you weren't referring to any particular phrase that I used?
A. I'm familiar with the issue --
Q. Okay.
A. -- right.
Q. Okay. Did you participate in provider financial strategy work group meetings where that issue was discussed?
A. I may have been in attendance at meetings where that was discussed.
Q. Did you participate in any of the discussions regarding that transition?
A. I did not.
Q. Did you consider it at all relevant to those discussions that you are aware of the existence of rebates and discounts on drug acquisitions for providers?
MR. COCO: Objection.
A. I did not.

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Q. Okay. Why not?
A. I didn't see the connection.
Q. Well, if what was being contemplated was moving from a percentage of bill charges to an AWP-based methodology and you're aware of the fact that providers purchased drugs at a discount and get rebates off them, wouldn't you consider that relevant to a determination of whether or not an AWP methodology should be adopted?
MR. COCO: Objection.
A. I'm not following the question.
Q. Okay. In moving from a percentage of bill charges to an AWP-based methodology for hospital outpatient departments, did you consider it relevant to the issue what those hospital outpatient departments were actually paying to buy the drugs?
A. I did not.
Q. Now, another area that you mentioned responsibility for is e-Health initiatives?
A. Correct.
Q. Can you describe for me what that is about?

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A. It's essentially supporting a number of pilot programs to put new technologies out in the physician offices to help them improve the quality of care delivered to patients.
Q. And what sort of initiatives or technologies?
A. E-Prescribing -- we launched an e-Prescribing pilot. We launched a couple of EMR and Medical Decision Support pilots, those kinds of activities.
Q. And the seventh area you mentioned was working with provider support teams?
A. Correct.
Q. What are the provider support teams?
A. They're the folks that are responsible for making sure that providers are able to pass us HIPAA-compliant claims and make sure that as we begin the migration to this national provider identifier system, that we're able to process the claims and that the providers are able to get them to us.
Q. Is the focus of those teams primarily on